

PATIENT ACCOUNT NUMBER

# PATIENT REGISTRATION FORM

DATE



**IRBY EYE CENTER**

204 GATEWAY NORTH, SUITE A MARBLE FALLS, TX 78654

NEW

CHANGE

## 1) PATIENT INFORMATION

*(Please write information about the patient here.)*

PATIENT'S NAME (First, Middle Initial, Last)			SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	
PATIENT'S ADDRESS				
CITY	STATE	ZIP	EMPLOYER'S NAME	TELEPHONE
TELEPHONE	SOCIAL SECURITY NUMBER	DATE OF BIRTH ____/____/____	EMPLOYER'S ADDRESS	CITY STATE ZIP
AGE	DRIVER'S LICENSE NUMBER	SPOUSE'S NAME	EMPLOYMENT STATUS <input type="checkbox"/> Full Time <input type="checkbox"/> Retired <input type="checkbox"/> Part Time <input type="checkbox"/> Not Employed	STUDENT STATUS: If 19 Years or Older: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Not a Student

## 2) HOW DID YOU HEAR OF US?

## 3) MEDICARE INFORMATION

*(Please write information about the patient's insurance here.)*

NAME AS IT APPEARS ON CARD
MEDICARE NUMBER

## 4) MEDICARE SUPPLEMENT INFORMATION

INSURANCE COMPANY	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Worker's Comp.
INSURANCE COMPANY'S ADDRESS	TELEPHONE
CITY	STATE ZIP
GROUP PLAN NUMBER	POLICY OR SUBSCRIBER'S NUMBER

## 5) PRIVATE INSURANCE

PRIMARY POLICYHOLDER'S NAME (First, Middle Initial, Last)	DATE OF BIRTH ____/____/____
RELATIONSHIP TO PATIENT <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Self	
INSURANCE CO. NAME	
POLICY # GRP #	
INSURANCE CO. ADDRESS	
CITY	STATE ZIP
IF CHAMPUS: <input type="checkbox"/> Active <input type="checkbox"/> Retired <input type="checkbox"/> Deceased	
Branch of Service:	

## 6) WORKER'S COMPENSATION

DATE OF INJURY	LOCATION
EMPLOYER'S NAME	
EMPLOYER'S MAILING ADDRESS (Street or P.O.)	
CITY	STATE ZIP CODE
INSURANCE CARRIER NAME & ADDRESS	
POLICY #	
SUPERVISOR'S NAME	
PHONE #	

**FOR NON-MEDICARE PATIENTS: PAYMENT FOR SERVICES IS DUE AT THE TIME OF SERVICE.**

I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claim.

I request that payment of authorized benefits be made on my behalf. I assign the benefits payable to which I am entitled including Medicare, private insurance and other health plans to the practice named on the other side of this form.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance, or considered a non-covered service.

ALTERNATE EMERGENCY PHONE # \_\_\_\_\_

**THANK YOU FOR YOUR COOPERATION**

X \_\_\_\_\_ DATE \_\_\_\_\_  
SIGNED (Patient, or parent if under 18 years of age.)